MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
AUGUST 7, 1997 REGULAR BUSINESS MEETING MINUTES

Adopted by the Task Force on November 21, 1997

Thursday August 7, 1997
107 South Broadway
First Floor Auditorium, Junipero Serra State Building
Los Angeles, California

I. CALL TO ORDER [Chairman, Alain Enthoven, Ph.D.] -- 9:30 AM

The sixth meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the First Floor Auditorium, Junipero Serra State Building in Los Angeles.

II. ROLL CALL AND DECLARATION OF A QUORUM -- 9:32 AM

Mr. Stuart McVernon of the Task Force staff took roll. The following Task Force members were present: Dr. Bernard Alpert , Mr. Rodney C. Armstead, Ms. Rebecca Bowne, Ms. Barbara Decker, Hon. Martin Gallegos, Dr. Bradley Gilbert, Mr. Terry Hartshorn, Mr. William Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O'Sullivan, Mr. John Perez, Mr. John Ramey Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. David Tirapelle, Mr. Ron Williams, and Mr. Steve Zatkin.

The following Ex-Officio members were present: Ms. Marjorie Berte, Mr. Keith Bishop, Mr. Michael Shaperio, Ms. Kim Belshe, and Dr. David Werdegar.

Once roll was called, Chairman Enthoven declared a quorum was present.

III. OPENING REMARKS

Chairman Enthoven opened the session by stating that Task Force has been asked to review the existing regulatory framework for the managed care industry of California, and if deemed appropriate, to make recommendations so that any regulatory framework [existing or new] can function effectively, satisfy patients, and control costs. Chairman Enthoven suggested that in thinking through this issue, members might be interested in the article "Making Health Plans Accountable for the Quality of Care" by Clark Havighurst, a distinguished professor of law at Duke University.

Chairman Enthoven stated that given the high interest in this issue, without objection, the discussion of the Task Force's role on legislation scheduled for later in the day would be moved so that it immediately proceeds New Business. Seeing and hearing no objection, the item was moved.

PUBLIC COMMENT:

Mr. Jamie Court, Director of Consumers for Quality Care Consumers Advocate - asked the Task Force to send a message to the Governor stating that it [Task Force] does not legislate and that Governor Wilson should not veto health reform bills solely on the basis that the Task Force is reviewing managed care and will come out with recommendations in January 1998. Mr. Court

stated that patients benefiting from such reform [as proposed in the patients bill of rights bill package] cannot wait another year for such changes to occur.

IV. CONSENT CALENDAR

Chairman Enthoven said that the next order of business was the adoption of the Consent Calendar, which contained two items: the proposed June 20, 1997 business meeting minutes and an amendment to the Task Force meeting and hearing schedule to add additional meetings. Mr. Hauck then moved that the Consent Calendar be adopted. Mr. Perez seconded the motion and it was adopted unanimously.

V. NEW BUSINESS

Chairman Enthoven and Task Force Deputy Director Alice Singh to introduce the next item of business. Deputy Director Singh stated that the next item before the Task Force was the adoption of an amendment to the Task Force Bylaws to allow for the creation of Policy Options Work Groups [POWGs]. Mr. Hauck moved to adopt the proposed amendment. Mr. Perez seconded the motion and it was adopted unanimously.

VI. TASK FORCE DISCUSSION

A. Discussion Of The Task Force's Role Regarding On Going Legislation

Chairman Enthoven then moved to Task Force Discussion and said that the Task Force has not been asked, not does it intend, to review and comment on specific bills because the Task Force is not a legislative body. Instead, the Task Force has been asked to provide a "coherent overall recommended framework for how this industry [health care] should be regulated."

He then invited Assemblywomen Susan Davis and Liz Figueroa to address the Task Force on managed care legislation. Specifically, Ms. Davis discussed her bill [AB 1354] which was recently vetoed by Governor Wilson. The Governor cited the Task Force in his veto message of the bill, which would have allowed a woman direct access to an OBGYN, stating that he [the Governor] wanted to refrain from signing any managed care legislation until the Task Force publishes its findings and recommendations in January 1998. Both Ms. Davis and Ms. Figueroa expressed their concern that the Task Force is being used as a rationale to veto legislation and urged the Task Force to clarify its role with regard to legislation. Ms. Figueroa further suggested that some managed health care legislation be allowed to move forward this year without objection by the Task Force.

Mr. Shapiro urged the Task Force to encourage the Governor to reverse his decision to veto any more HMO bills until the Task Force has made it's final report in January.

Ms. Bowne asked the Task Force not to let individual incidents and circumstances influence the creation of "bad policy", while Mr. Lee pointed out that reviewing legislation would be a distraction for the Task Force. He further argued that the Task Force needs to be a complementary entity of the legislative process.

Dr. Rodriguez-Trias proposed that the Task Force make a clear statement regarding our role to make recommendations, not specifics.

Ms. O'Sullivan recommended that the Task Force send a delegation to the Governor [including the Chairman] to ask him to consider bills based on their merits.

Mr. Hiepler said that he wanted the Task Force to make a statement that its role is not to impede the process of legislation and that bills should be judged on their own merit.

Mr. Kerr moved to adopt a statement that the Task Force "…strongly encourages the public, the legislature, and the governor to engage in an ongoing, constructive dialogue today, as well as tomorrow, about how best ensure our health care system meets the needs of Californians for high quality, accessible, affordable health care…". The motion was seconded by Mr. Hauck and after a lengthy discussion amongst Task Force members, amended by a motion made by Mr. Kerr and seconded by Mr. Perez. The motion to adopt the following statement was passed unanimously:

> *The California Managed Health Care Improvement Task Force was established by the California Legislature to inform the public, the State Legislature and the Governor about managed health care and its impact, and to make recommendations on ways to improve managed health care for the benefit of the public.*
>
> *The Task Force intends to provide the public, the Legislature and the Governor with a significant report that specifies recommended actions to improve the California health care system, including structural issues and accountability to the public, and improve the health of all Californians.*
>
> *The Task Force informs the public, the Legislature and the Governor that we have not been asked and do not intend as a Task Force to comment on individual legislative bills, but rather to state our systemic findings and recommendations to help inform both private and public policy development.*
>
> *Therefore, the Task Force strongly encourages the public, the Legislature and the Governor to engage in an ongoing, constructive dialogue today, as well as tomorrow, about how to best insure that our health care system meets the needs of Californians for high quality, accessible, affordable health care.*
>
> *The Task Force supports that managed health care legislation be considered on its merits, and the Task Force process should not impede the legislative process.*

Short Recess

Following the break, Ms. O'Sullivan made a motion that the Task Force send a delegation meet with Governor Wilson on this issue to express the statement just adopted by the Task Force. Mr. Perez seconded the motion, but after some discussion, the motion failed with 14 affirmative votes.

VII. ORAL REPORTS/PRESENTATIONS

A. Task Force Expert Resource Groups:

1. Streamlining [Members Ms. Kathryn Murrell and Mr. Ronald Williams].

Mr. Williams addressed five topics relating to regulatory simplification:

- *structural issues* (oversight by Department of Corporations (DOC) versus Department of Insurance (DOI)) - Mr. Williams stated that DOC focuses on assessing service delivery and quality while DOI focuses on financial stability. He felt that this division works well.
- *documentation* that health plans are required to submit to regulators - Mr. Williams recommended development of consistent criteria for amendments and material modifications so that both agency staff and health plans could apply the criteria accurately. He also made recommendations about procedural issues. He felt these changes would lead to continued innovation and increased market responsiveness.
- *medical group oversight* - Mr. Williams recommended uniformity and equity in audit procedures for provider groups, recognizing that these groups are often actually managed by a third party such as a medical services organization.
- *audit redundancy* - Mr. Williams stated that there are substantial opportunities for establishing audit standards across regulatory agencies. He also recommended that plans that have met national accreditation standards, such as the National Committee for Quality Assurance (NCQA) standard, should be approved for state regulatory purposes.
- *agency resources* - In addition to enhanced DOC funding, Mr. Williams recommended that the DOC staff receive additional training to "ensure consistency and accuracy in the review process."

Task Force members asked Mr. Williams questions about regulating medical groups directly through an oversight agency versus indirectly through a health plan; financial solvency and risk issues for medical groups; appropriate kinds of staff for the regulatory agency; and how to address the needs of consumers who are in plans outside of current state regulation (e.g., self-funded plans).

2. Practice of Medicine [Members Dr. Bernard Alpert and Dr. Bruce Spurlock]

Dr. Spurlock stated that he and Dr. Alpert focused on the issue of how to decrease disagreement over medical necessity and improve decision quality. He described studies that show there is a lot of unwanted clinical practice variation in California and the US. To address this problem, he recommended increased use of evidence-based practice guidelines that incorporate patient preferences and values. He stated that individual patient variation and a thorough understanding of all relevant information should be considered when these guidelines are applied. Dr. Spurlock also recommended that disputes be resolved at the physician-patient level, but that patients should have recourse beyond their individual physician as well.

Dr. Alpert described two cases involving confusion over medical necessity and used them to illustrate the ERG's recommendations on this topic. He first discussed an Arizona case in which a plan's medical director reviewed a member's medical record and determined that the member's surgery was not medically necessary. The state's Department of Insurance found that the medical director was not liable for the decision, while the state's Board of Medical Examiners found that he was liable. Ultimately, the Court of Appeal determined that the medical director was liable. Dr. Alpert recommended that "all parties making medical decisions, whether by the traditional direct

contact route or by other more removed methods... should be held accountable to the same standards."

Dr. Alpert then discussed the pre-authorization or concurrent authorization process, stating that the insertion of this bureaucratic process can lead to poor medicine and bad outcomes. He recommended that the pre-authorization process be eliminated or modified with available electronic technology. He further recommended pre-credentialing providers, using post-utilization review of practice patterns, and using practice guidelines.

Task Force members discussed experimental therapies; referrals between primary care providers and specialists versus referrals between sub-specialists; population-based versus individual-based decisions; and how to align patient and physician expectations.

3. Dispute Resolution Process [Members Ms. Barbara Decker and Mr. Peter Lee]

Mr. Lee began by stating that disputes should be resolved at the lowest possible level (i.e., the doctor's office) and that grievance data should inform quality improvement efforts. He then introduced two guests: Mr. Tom Guyser, Executive Vice President, General Counsel, Wellpoint; and Mr. Harry Christie, a Task Force alternate member.

Mr. Guyser described three elements of the dispute resolution process for Blue Cross of California: how the problems come to the plan's attention, the plan's method for third-party intervention, and the plan's dispute resolution feedback loop.

Mr. Christie shared his family's experience with the dispute resolution process when his daughter was diagnosed with a rare cancer. He reviewed the steps he went through with the medical group, health plan, arbitrator, and regulatory agency. He stated that the entire process took nearly three years. He recommended that HMO review processes be open to outside medical scrutiny.

Task Force members discussed the high consumer costs of arbitration and asked for clarification from the two speakers.

Mr. Lee outlined some "essential elements" of dispute resolution for the Task Force to consider: disputes should be resolved at the lowest possible level; consumers need to understand their rights, responsibilities, and the plan's dispute resolution process; some consumers will need assistance to navigate the process; the processes need to be perceived as fair; the findings need to be communicated to the consumer; the process needs to treat like consumers alike and must be efficient from both the plan's and consumer's perspective; the process must have appropriate finality and it must help improve system-wide problems.

Ms. Decker described potential recommendations, including

- all enrollees in managed care plans should have the same procedural rights and protections regardless of the plan type or the purchaser;
- all consumers should be informed of their rights and responsibilities, including avenues for pursuing complaints, upon enrollment and whenever a potential misunderstanding arises;
- some consumers may need access to an independent external source of assistance in the dispute resolution process;
- regardless of plan type, plans' internal processes should have common standards, including time frames;
- the basis for decisions should be shared with consumers, while maintaining patient confidentiality, to establish precedents;

- there should be an independent third-party review available to all consumers at some point in the process;
- the state should establish arbitration standards; and
- the efficacy of a full range of dispute resolution mechanisms should be explored.

Mr. Lee circulated to the Task Force as a public document a list of fifteen questions regarding potential recommendations.

The Task Force members discussed the importance of this issue; barriers to early compromise; and financial incentives.

Lunch

B. Managed Health Care Oversight

1. Private Sector Efforts in Managed Care [David Hopkins, Ph.D., Director of Health Information Improvement, Pacific Business Group on Health]

Dr. Hopkins described PBGH and its efforts to improve quality. The organization measures quality by conducting member satisfaction surveys at the health plan and medical group levels. The results are used to produce report cards that are distributed to consumers. PBGH also builds performance measures into their health plan contracts. They put 2% of the premiums at risk for certain measures.

Dr. Hopkins also discussed data issues. He recommended implementing electronic medical records, electronic data interchange, making data available in real time to providers, universal patient and provider identifiers. He also recommended that the Task Force support private sector initiatives and encourage public-private partnerships. Finally, he recommended that the state use its purchasing clout to advance data and quality improvement initiatives.

2. The State's licensure and certification of hospitals and facilities [Mary Retzer, MD, Licensing and Certification Division, Department of Health Services]

Dr. Retzer described Licensing and Certification (L&C) Division's staffing and basic functions, which include licensing 30 types of facilities and providers so they can do business in California; certifying facilities and providers as eligible for payment under the federal Medicare and Medicaid programs; certifying certain types of health care professionals; educating consumers and providers; and investigating complaints.

Task Force members asked Dr. Retzer about the quality of care in California facilities; certification of specialized centers of excellence; nursing skill levels in acute care settings; and reducing audit redundancies.

3. **<u>The State's licensure and regulation of medical doctors</u> [CA Medical Board - Stewart Hsieh, J.D., President of the Board, Karen McElliot, Secretary of the Board and Alan E. Shumacher, M.D.]**

Dr. McElliot gave an overview of the Medical Board's structure and purpose. She stated that the Board has created a Quality of Care in a Managed Care Environment committee that is similar to the Task Force. She stated that there is a breakdown of the public's trust due to managed care and recommended that the Task Force devise a regulatory mechanism that has the interest of the consumer as its primary mission. She suggested that the "regulation of the managed care facilities should be in the hands of the Medical Board."

The Task Force members asked the panelists questions about outcomes of the Board's oversight efforts; necessary functions of an oversight agency; whether any other state uses its Medical Board to oversee managed care; how many physicians have actually been disciplined by the Board; clarification on the scope of regulatory activity they are recommending; and conflict of interest issues.

4. **<u>The State's licensure and regulation of nurses</u> [Ms. Geri Nibbs, Supervising Educational Consultant for the CA Board of Registered Nursing]**

Ms. Nibbs described issues that were brought up in four forums the Board of Registered Nursing convened. The nurses at the forums were most concerned with the substitution of unlicensed assistance personnel for registered nurses. She stated that these unqualified individuals were assessing, triaging, and providing care to patients at a level they were not prepared to do. The nurses were concerned that patients would be harmed as a result.

Ms. Nibbs recommended that consumers and all health care professionals be represented in any oversight agency the Task Force might recommend and that practice barriers for advanced practice nurses be removed.

Task Force members asked for more details about the substitution of unlicensed personnel.

5. **<u>Managed Health Care Oversight</u> [Ms. Chris Selecky, former president of a major managed care organization in California].**

Ms. Selecky described the evolution of the managed care system from one "which was focusing on managing care to one that focused on managing costs." She stated that regulatory oversight does not focus on outcomes because there is insufficient data and instead focuses on processes. She felt that the regulatory process is fragmented and duplicative and leads to increased administrative costs without improving quality of care. She recommended that the Task Force look for a regulatory model that everyone can agree has worked well and use that model as a template.

VIII. PUBLIC COMMENT

Chairman Enthoven stated that without objection, public comment would be deferred until the public hearing which would be conducted in a matter of minutes. Seeing and hearing no objection from members or the public, the Chairman deferred public comment.

IX. ADJOURNMENT [Chairman] 4:04 p.m.

Chairman Enthoven stated that without objection, the business meeting would be adjourned. Seeing and hearing no objection, the Chairman adjourned the meeting.

Prepared by Task Force Staff